EXHIBIT 86

RETAIL PHARMACY QUESTIONNAIRE

Mandatory – Form will not be processed unless all questions are completed

Servicing Distributions Center(s) _____

Name / Phone Number of BDM or Account Manager:_____

This questionnaire is to be completed by the Owner and Business Development Manager during an on-site visit

1. Pharmacy Name: _____
   a. ABC Account number_____
   b. Pharmacy's dba (doing business as), if any _____
   c. Has the pharmacy ever operated under a different name?
      Yes____ No____ If yes, provide the Name:
      _____
   d. Will ABC be this customer's primary wholesaler? Yes____ No ____
   e. Has this customer signed a Prime Vendor agreement? Yes___ No___ (**Certain Controlled Substances may be restricted absent a PVA)**
   f. Does this customer have a PVA or equivalent with any other wholesaler?
      Yes___ No___ If yes, name _____

2. Pharmacy Address: _____
   a. City_____
   b. State_____
   c. Zip_____

3. Pharmacy Phone Number: _____ Fax Number: _____

4. Pharmacy Email Address: _____

5. Check one:
   ☐ Start-up business. Other suppliers _____
   ☐ Existing business adding or changing suppliers. Identify any secondary suppliers customer intends to utilize._____
   Identify prior suppliers _____
   Has a supplier ever suspended or ceased controlled substance sales to the pharmacy? ____Yes ____No
   If yes, why_____
   ☐ Existing ABC Customer. Account # _____
   a. Has been customer of ABC: Years_____ Months_____
   b. Customer's current ratio of CS to Non-CS invoice lines % _____
   c. Customer's total monthly dollar purchase volume w/ABC _____

6. Name of pharmacist –in –charge (PIC) as it appears on the license
   _____

7. PIC's state license number: _____

8. Has the PIC ever been sanctioned/disciplined in any state(s) where they are or have been licensed?
   Yes____ No____ If Yes, give details (when, why, etc.)
   _____
   _____
   _____

9. Is this pharmacy affiliated with any other pharmacy?
   Yes____ No____ If yes, provide the following:

   Name: _____
   Address: _____
   Phone Number: _____Fax Number:_____

   Note: If there are additional affiliates please attach an additional sheet with the information

10. Ownership type: Check one
    a. Sole Proprietor ____ Corporation_____ Partnership____
       Other _____ (describe)

11. Owner(s) name: _____

12. Owner State of Residence: _____

13. Owner Phone Number: _____ Fax Number: _____

14. Owner Email Address: _____

15. Number of years owner has operated pharmacy _____

16. Is the Owner a licensed pharmacist?
    Yes____ No____

17. Pharmacy DEA registration #: _____

18. State BOP license #_____

19. Does pharmacy have a valid Self-Certification to sell scheduled listed chemical products? Yes____ No____

20. Has the Pharmacy ever had a DEA registration suspended or revoked?
    Yes____ No____ If so, give details (when, why, etc.)
    _____
    _____

21. Has the Owner, family member, or any employee of the pharmacy ever had a DEA registration suspended or revoked?
    Yes____ No____ If so, give details (when, why, etc.)
    _____
    _____

22. Does the pharmacy have any other licensure/registration (wholesale, repackager, etc…)?
    Yes____ No____ If so, provide copies.

23. Is the pharmacy a "specialty" pharmacy?
    Yes____ No____ If yes, describe_____

24. What percentage of the following describes the pharmacy's business activities?

    _____% Retail
    _____% Long Term Care
    _____% Compounding
    _____% Infusion
    _____% Other (explain) _____

25. Check the following manners of receiving business and provide what percentage of the total business it comprises:

Walk-In	Yes____	No____	_____%
Phone	Yes____	No____	_____%
Fax	Yes____	No____	_____%
Internet/Mail Order	Yes____	No____	_____%

26. Which state(s) does the pharmacy ship into (if any)? _____
_____

27. Is the pharmacy licensed for sales in all states it distributes to?
Yes____ No____

28. Are all prescriptions written by physicians located in the state in which the patient resides?
Yes____ No____

29. Does the pharmacy have written policies and procedures regarding the filling of prescriptions?
_____ Yes _____ No If yes, attach pertinent sections.
    a. How many prescriptions are filled daily_____; monthly_____?
    b. Percentage of prescriptions that are controlled substances_____%
    c. Verification process _____
    _____
    d. Does the pharmacy use the State Rx monitoring program? ____Yes ____No ____ N/A
    e. Does the pharmacy verify the physician's state license and/or DEA registration? ___ Yes ___ No
    f. Does the pharmacy engage in discussions with prescribing physicians? ___ Yes ____ No If yes, how documented? _____
    g. What is the pharmacy's procedure for reporting fraudulent Rx's?
    _____

30. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA/OTC	Yes____	No_____% of total purchases
Non-Controlled Rx	Yes____	No_____% of total purchases
Controlled Substances	Yes____	No_____% of total purchases
Listed Chemicals	Yes____	No_____% of total purchases

31. Anticipated or actual usage of certain controlled substances:

Item	Monthly Usage Values in # of tabs	Average Tablets per Prescription	Average Days Supply per Prescription
Oxycodone Combination Products			
Hydrocodone Combination Products			
Methadone			
Alprazolam			

List top 5 prescribing physicians ranked by volume of prescriptions for OX or HY, whichever is greater:

Name	DEA Registration	# Prescriptions Monthly	% to overall prescription volume

32. Does the pharmacy have a web site?
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon establishing a web site.

33. Is the pharmacy affiliated with a web site?
Yes____ No____ If yes, provide web address(es):
_____
Note: If no, you are required to notify us immediately upon affiliating with a web site.

34. Will the pharmacy download and fill prescriptions on a per prescription fee basis from a website for dispensing?
Yes____ No____ If yes, provide web address(es):
_____

35. Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:

Private Insurance	Yes____	No____	_____% of revenue
Medicare/Medicaid	Yes____	No____	_____% of revenue
Cash	Yes____	No____	_____% of revenue
Other	Yes____	No____	_____% of revenue

If other, provide details _____

36. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).

OTHER COMMENTS/OBSERVATIONS

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Retail Pharmacy Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

OWNER:
Name of Entity/Person
By: _____

_____
Name:

_____
Title:

_____
Date:

I, as the authorized AmerisourceBergen representative, declare that I have reviewed this Retail Pharmacy Questionnaire with the owner or [authorized representative or officer of Owner] and to the best of my knowledge and belief the information provided is true, correct and complete. **I therefore recommend opening this account.**

AMERISOURCEBERGEN ASSOCIATE:
Signature_____

_____
Full Name (Print)

_____
Title

_____
Cell Phone Number